Subject Name: _____ SSN _____ **Date** _____

Title of Study: H02-131 Telemedicine Intervention to Improve Depression Care in Rural CBOCs

Principal Investigator: Dean Robinson, M.D. **VAMC:** Shreveport, LA

Authorization for Release of Protected Health Information for Research Purposes

You have been asked to be part of a research study under the direction of Dean Robinson, M.D. and his research team. The purpose of this research project is to improve treatment for people with depression who live a long distance from a VA medical center. By telemedicine, we mean using a telephone, interactive video (a video camera connected to a TV) and computerized medical records to improve your access to quality care.

By signing this document, you will authorize the Veterans Healthcare Administration (VHA) to provide Dr. Robinson and his research team to access the following information about you that is relevant to the research project identified above and in VA Consent Form 10-1086: (1) the diagnoses your doctor recorded for you in the past and over the next 12 months; (2) the prescriptions your doctor wrote for you in the past and over the next 12 months; (3) the prescriptions you filled and refilled over the next 12 months; and (4) the type and cost of health services provided to you in the past and over the next 12 months.

If you do not sign this authorization, you will not be part of the study.

This authorization to use your information will expire at the end of the research study.

While the research study is in progress, your right to access any research records or results that are maintained by the facility may be suspended until the research study is over. If your access is denied, you understand that it will be reinstated at the end of the research study.

You can revoke this authorization at any time. To revoke your authorization, you can write to Dr. Robinson or you can ask a member of the research team to give you a form to revoke the authorization. If you revoke this authorization, you will not be able to continue to participate in the study. This will not affect your rights as a patient of VHA.

If you revoke this authorization, Dr. Robinson and his research team can continue to use information about you that has been collected. No information will be collected after you revoke the authorization.

I understand that copies of the records indicated above will be:

- Used by employees of Overton Brooks VA Medical Center-Shreveport including treatment providers, and/or other members of its workforce.
- Disclosed to government officials or government agencies, study sponsors, study monitors, or others responsible for oversight of the research project.
- Sent to collaborating researchers outside Overton Brooks VA Medical Center-Shreveport if and to the extent indicated in the attached Informed Consent document(s).

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Persons who are authorized to receive and use this information are:

(1) Overton Brooks VA Medical Center treatment providers, study personnel and members of the Research and Development Committee;

(2) LSUHSC-S treatment providers (if applicable), study personnel and members of the Institutional Review Board;

(3) and the United States Food and Drug Administration (FDA).

I understand that by signing this form, I will allow Overton Brooks VA Medical Center-Shreveport and its researchers to use or disclose my health information in connection with the attached Informed Consent and for the purpose of the research that is described in the Informed Consent. For example, the researchers may need the information to verify that I am eligible to participate in the study, or to monitor the results, including expected or unexpected side effects or outcomes. Other University and government officials, safety monitors, and study sponsors may need the information to ensure that the study is conducted properly. Also, I understand that my health information may be disclosed to insurance companies or others responsible for my medical bills (if applicable) in order to secure payment.

The VHA complies with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its privacy regulations and all other applicable laws that protect your privacy. We will protect your information according to these laws. Despite this protection, there is a possibility that your information could be used or disclosed in a way that it will no longer be protected. Our Notice of Privacy Practices (a separate document) provides more information on how we protect your information. If you do not have a copy of the Notice, the research team will provide one to you.

I have read this authorization form and have been given the opportunity to ask questions. If I have questions later, I understand I can contact Dr. Robinson. I will be given a signed copy of this authorization form for my records. I authorize the use of my identifiable information as described in this form.

_____ _____

Participant's Signature Date

REVISED
APPROVED

IRB APPROVAL: Start Date: 10/18/03 End Date: 10/17/04